AN EXPLORATORY DESCRIPTIVE STUDY OF THE SIGNIFICANCE OF SELF-ESTEEM, ANXIETY AND SOCIAL SUPPORT ON TEEN PREGNANCY

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

VELMA M. TYLER

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

MAY 1995

R=iv P=63

(c) 1995

Velma M. Tyler

All Rights Reserved

ACKNOWLEDGEMENTS

"Thank you God," for your grace and mercy brought me through, I'm living this moment because of You.

I would like to express heartfelt thanks and deep appreciation to my children Jermaine and JeQuane Tyler, my parents Mr. and Mrs. Quincy McKie, my brothers Gregory and Curtis for your prayers, support, patience, trust and love. Each of you have truly helped make my goal a reality.

This day is dedicated to each of you. Thank you from the bottom of my heart.

To Professor Hattie M. Mitchell, a special thank you for your guidance, patience and friendship shown in the completion of my thesis. Dr. Amos Ajo, thank you for your assistance with my data analysis. I shall never forget each of you.

"I can do all things through Christ which strengtheneth me."
Philippians 4:13

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Adolescent pregnancy and parenthood is a social phenomenon, and is largely an unintended consequence of adolescent sexual behavior. This social phenomenon has generated national and international attention due to the legal, moral, religious, emotional, social and health issues it continues to engender.

This has been a phenomenon for decades, and one that will continue to face our society as we rapidly approach the year 2000. Adolescent pregnancy has proven to be an issue not easily eradicated. It continues to be a social problem requiring social workers to continuously investigate systematically, its magnitude, causations and consequences on present and future generations of adolescent females, males and their families.

The United States leads all other developed nations in the incidence of pregnancy among adolescents aged 15 through 19. The rate of pregnancy and child bearing in this age group is considered among the highest of any Western Nation including those with comparable levels of sexual activity. U.S. adolescents are twice as likely to become pregnant and parents as Canadian adolescents, three times as likely as Swedish adolescents.[1] Robinson and Frank (1994)[2] indicate an increase in sexual activity among the adolescent population with an estimated 50-58% being sexually active, thus suggesting teen pregnancy will continue to be a major problem facing our society.

---

[1]Frank F. Furstenberg, "Pregnancy and Childrearing: Effects on Teen Mothers," Encyclopedia of Adolescence, Vol. II, New York: Garland Publishing, Inc., 1991, 803-807.

[2]Rachel B. Robinson and Deborah L. Frank. "The Relation Between Self-Esteem, Sexual Activity and Pregnancy," Adolescence, Vol. 29, No. 113, Spring 1994.

It has been estimated that 50 percent of Caucasian females, and 75 percent of African American females become sexually active before the age of 18 years, consequently projecting 20 percent of Caucasian females and 40 percent of African American females will become pregnant before adulthood.[3] African American adolescents had the highest birth rate (87 births per 1,000 in 1982) of all adolescent females under age 20. Caucasian adolescents had the highest out-of-wedlock pregnancies, 62 percent.[4] Becerra and Filder (1987) also note the rate for African American adolescents (married and unmarried) fell sharply more than Caucasian adolescents. The decline in African American pregnancies is associated with a reduction in non-marital birth rate.

For adolescent pregnancies there is no one causative factor, nor one problem that will be encountered by the adolescent parent. It is of importance to note that there will be a multiplicity of problems. Lander (1985) proposes this problem will affect three generations; the teen parents, their children, and the grandparents.[5]

Indicative of such will be increasingly negative social and psychological consequences. Including, but not limited to, low self esteem, anxiety, depression, feelings of social isolation, and anger. Adolescent pregnancy also increases the probability of a negative life outcome for both teen mothers and their children. They are more likely to drop out of school due to pregnancy, receive welfare, become homeless, or have large families. Research has indicated some

---

[3]S.J. Ventura & R.L. Heuser, "Trends in Teenage Childbearing, United States," 1970-81: Vital and Health Statistic Series 21, No. 41 DHHS Pub. No. (PHS) 84-1919; Rockville, Maryland: National Center for Health Statistics, (Sept. 1984) 3.

[4]Rosina M. Becerra and Eve P. Filder, "Adolescent Pregnancy." Encyclopedia of Social Work, Vol. 1, 18th ed., 40-50; Maryland: National Association of Social Workers, Inc., 1987.

[5]J.A. Lander, "Teenage Pregnancy: The Implications for Black America," Washington, D.C.: New Directives, 1985, 65-84.

adolescent females seeking approval and acceptance may turn to sexual behaviors without clearly understanding the ramification of such involvement.

Statement of the Problem

The high incidence of adolescent pregnancy has been viewed as a social phenomenon since the 1960's. In that era, there were 7 million pregnant females ages 15-17. Resulting from the baby boom of the 70's, there were 10 million adolescent females, an increase of 35 percent.[6]

One out of every 10 females, ages 15-19, in the United States become pregnant each year. 837,000 among females 15-19 and 23,000 among 14 and younger.[7] Such statistical data illuminates the unprecedented magnitude of this problem facing our society. Coates and Brigit (1991) have estimated 8.7% of adolescents will have one or more abortions by age twenty.[8]

Adolescence and parenthood are significant turning points in the life cycle. Parenthood and the demands for adaptation of new roles generate stress and dramatic changes in the family structure. The labor market has also left young Americans vulnerable to negative health, psychological, social and economic effects of early pregnancies. AIDS now poses the risk of devastating consequences for those teens who have chosen to be sexually active and for their children.

---

[6]Rosina M. Berra & Eva P. Filder, "Adolescent Pregnancy," Encyclopedia of Social Work. Vol. I, (18th ed.) (1987) 40-50.

[7]James Trusell, "Teenage Pregnancy in the United States," Family Planning Perspectives, Vol. 20 (1988), 262-272.

[8]Deborah L. Coutes and Brigit Van Widenfelt, "Pregnancy in Adolescence," Encyclopedia of Adolescence, Vol. II, Garland Publishing, Inc., New York, 1991, 794-796.

Concerns about this social problem increased for several reasons: (1) The birth rate of non-adolescent women has decreased significantly whereas that of adolescents has declined less; (2) the decline is in the adolescents ages 18-19, while the birth rate is actually increasing among younger adolescents (ages 15-17); (3) the number of out-of-wedlock pregnancies has risen for adolescents; (4) the greatest increase in adolescent out-of-wedlock pregnancies has been among Caucasian adolescents (although the birth rate is higher for African American adolescents, the rise in the adolescent birth rate has been confined to Caucasians); (5) public funds for the care of young adolescent mothers an their children have increased.[9]

Fewer teens are marrying today, thus the vast majority of infants are born to unwed mothers. These infants have risks of developmental delays, behavior problems, health complications and academic problems in later life.

Significance / Purpose of the Study

Teenage pregnancy has been reiterated consistently, for several decades, as a major concern of social service providers, educators, researchers, and public officials. Efforts to understand its causalities have generally focused on the issues of ones individual choice regarding the decision to engage in sexual behavior or to utilize contraceptive devices.

Society now voices abstinence, yet statistics continue to illustrate, "Babies are having babies," the term most utilized to describe adolescent pregnancies in this century.

Adolescent pregnancy is viewed as a period of major social change, a time when the expectant mother must redefine her relationships to

---

[9]W. Baldwin, Encyclopedia of Social Work, S.V. "Adolescent Pregnancy" by Rosina M. Becerra and Eve P. Fielder. Maryland: National Association of Social Workers, Inc., Vol. I, 18th ed., 1987, 40-50.

significant others in her life, and how these significant others contribute in the formulation of social support. Attention will be given to social support and its effectiveness or lack of in helping teens with this stressful life event.

The purpose of this exploratory descriptive study will be to examine the perceived impact of self-esteem, anxiety and social support on teen pregnancy. It will determine if there are significant relationships between self-esteem, anxiety, and social support on adolescent pregnancy. Focusing on an adolescent's self-esteem is essential. Development of a positive self-esteem is a major task of developmental growth.

One of the most widely accepted ideas in the behavioral sciences is the concept of adolescence being recognized as an age of "storm and stress," one in which children experience a disturbance of their self image.[10]

Knowledge and data obtained from this study will be crucial and significant for social workers in their understanding of pregnant adolescents' self-esteem, anxiety and social support from family, friends and significant others, and how such can be utilized effectively to assist the adolescence in coping with the emotional and biological changes occurring in their bodies as well as enhancing self-esteem.

---

[10]Alfred Freedman, M.D., Modern Synopsis of Comprehensive Textbook of Psychiatry, II, The Williams & Williams Company, 428E. Preston Street Copyright, 1976, 137.

CHAPTER II

REVIEW OF THE LITERATURE

Adolescent pregnancy is a social phenomenon affecting American youth from rural and urban areas, of all socioeconomical levels and from all racial and ethnic groups. While it may generate difficulty in one's understanding of the magnitude of concerns and motivational variables, pregnancy exists.

In a review of social work literature, indications are emanated that adolescent mothers and their children face formidable obstacles to their physical health, psychological functioning, economic opportunities and educational attainments. Records (1993) indicates the social, educational and economic consequences of early pregnancy have been abundantly documented. Adolescent parents are likely to leave school earlier and have lower life time earnings than those teens who delay pregnancy. Economically disadvantaged and minority youth are noted to be particularly vulnerable to the stresses of being a young parent.[1] Rubestine, Panzarine and Lanning (1990) indicates pregnant adolescents younger than 15 years are at risk for delivering a low birthweight baby.[2] Card and Wise (1978) indicates when a comparison of adolescent peers who have postponed childbearing, pregnant teens have poorer educational and occupational achievement, a higher divorce rate and a greater reliance upon public welfare support.[3] Data suggest the

---

[1]Kathryn A. Records, "Life Events of Pregnant and Non-Pregnant Adolescents," Adolescence, Vol. 28, No. 110, (Summer 1993).

[2]Elaine Rubestine, Susan Panzarine and Patricia Lanning, "Peer Counseling With Adolescent Mothers: A Pilot Program," Families in Society: The Journal of Contemporary Human Services, (1990), 136-141.

[3]J.E. Card and L. Wise, "Teenage Mothers and Teenage Fathers: The Impact of Early Childbearing on Parent's Personal and Professional Lives," Family Planning Perspectives, 10(4), (1978), 199-218.

children of adolescent mothers cognitive abilities and achievement are negatively affected (Baldwin and Cain - 1980).[4] A study of teenage mothers by Furstenberg, Brooks-Gunn, and Morgan (1987) states high school completion was of most importance in determining a successful outcome.[5]

Children of adolescent mothers have a great possibility of being reared in a single parent home, thus limitations may be placed on the accessibilities of competent role models and fewer social supports which in turn could limit the ability for growth in a "normal" functioning family and the development of heterosexual relationships. The regard for this social problem is not confined to the teenager, his family, but for society.[6]

Despite such obstacles, Records (1993) indicates 13% of babies born in the United States since 1985 have been to adolescents.[7] McKenna and Wiser (1994) measured the impact of adolescent pregnancy by utilization of vital statistics and population data from DeKalb County Georgia. Indicators were the number of births to females 10-17 years of age expressed as a percentage of all births in the population.[8]

During the period of 1982-1990, no significant changes occurred in the proportions of births to adolescents. Births to adolescents were 5.3 percent of all births during 1982-84; 5.2 percent of all births

---

[4]W. Baldwin and V. Cain, "The Children of Teenage Parents," Family Planning Perspectives, 11(4), (1980), 219-225.

[5]Frank F. Furstenberg, J. Brooks-Gunn and S. Morgan, "Adolescent Mothers in Later Life," Cambridge: Cambridge University Press.

[6]Bruce Armstrong, "Adolescent Pregnancy," Encyclopedia of Adolescence, Vol. II, Garland Publishing, Inc., New York, 1991.

[7]Kathryn A. Records, "Life Events of Pregnant and Non-Pregnant Adolescents," Adolescence, Vol. 28, No. 110, (Summer 1993).

[8]Matthew T. McKenna, M.D., M.P.H. and Paul J. Weisner, M.D., "Evaluation of the Consensus Health Status Indicator for Assessing Adolescent Pregnancies and Birth," Public Health Reports in Brief, Vol. 109, No. 4, July-August 1994.

during 1988-90. There was a significant increase in pregnancy rates from 27.9 per 1,000 births for 1982-84 to 33.1 per 1,000 for 1988-90. African American pregnancy rates increased in the age categories 10-17 years, 18-19 years, and 20-49 years. Caucasian pregnancies in each of the categories noted no significant change.[9]

Coates and Widenfelt (1991) indicate birth to teens have declined steadily since 1970. In the age group 15 to 19, decline in 1986 was 51 births per 1,000 from 68 per 1,000 in 1970. In 1987, 472,623 adolescent births represented a 100,000 birth decline since 1979. This decline, according to Coates and Widenfelt, is expected to continue for the next several years, and has been attributed to a slight decline in the birth rate, a decline in the adolescent population, and to an increase in adolescent abortions. Data collected in 1987 indicates about 44% of pregnant adolescents chose to abort.[10]

Trusell (1988) notes that of these pregnancies, five out of every six are unintended; 92 percent of those conceived premaritally and half conceived in marriage.[11] These researchable and statistical illustrations assist in making profoundly clearer the complexity and intensity of this social phenomenon. Social workers must examine and utilize data provided in making accurate assessments and provide effective interventions for the adolescent population.

This study examines the significance relationships of self-esteem, anxiety and social support on teen pregnancy. The adolescent teen is not born with self esteem; it is learned from infancy. Coping with

---

[9]Matthew T. McKenna, M.D., M.P.H. and Paul J. Weisner, M.D., "Evaluation of the Consensus Health Status Indicator for Assessing Adolescent Pregnancies and Birth," Public Health Reports in Brief, Vol. 109, No. 4, July-August 1994.

[10]Deborah L. Coates and Brigit Van Widenfelt, "Pregnancy in Adolescence," Encyclopedia of Adolescence, Vol. II, Garland Publishing, Inc., New York, 1991.

[11]James Trusell, "Teenage Pregnancy in the United States," Family Planning Perspective, Vol. 20, No. 6, November/December 1988.

the biological, physical and emotional experiences of pregnancy can manifest into a stress response of fear, depression, anxiety and low self-esteem. While sexual activity and resulting pregnancy may be viewed as means of bolstering self-esteem and sexual identity, research has not found this to be conclusive.

According to Trimpey (1989), high anxiety can interfere with problem solving and with the development of new coping patterns. Low self-esteem can accompany depression and powerlessness.[12] One has to stay cognizant that parenthood, when occurring simultaneously with the normative crisis of adolescence, brings about tremendous potential for a severe lack of fit between an adolescent's readiness to assume a parental role and the social environment's ability and/or willingness to respond (Armstrong 1991).[13]

Wells and Marwell (1976) conceptualized self-esteem from a theoretic construct of self as a global, internal sense of personhood developing through personal experiences, and confirmed by significant others. Self-esteem centers around the behavioral and emotional process by which the self is judged, evaluated, regarded or appraised.[14]

Coopersmith (1967) explores self-esteem in terms of evaluation, judgment, achievement and success. Ability and performance are measured standards. If achievement is determined to be a valued one, the impact on self-esteem will be greater. Positive self-esteem enables individuals to withstand events that challenge or contradict their evaluation of self.[15]

---

[12]M.L. Trimpley, "Self-Esteem and Anxiety in an Abused Women's Support Group," Issues in Mental Health in Nursing, Vol. 10, (1988), 297-308.

[13]Bruce Armstrong, "Adolescent Pregnancy," Encyclopedia of Adolescence, Vol. II, Garland Publishing, Inc., New York, 1991.

[14]L.E. Wells and G. Marwell, "Self-Esteem: Its Conceptualization an Measurement," Issues in Mental Health in Nursing, Vol. 10, (1988), 299.

[15]S. Coopersmith, The Antecedent of Self-Esteem, San Francisco: Friedman (1967).

In exploring anxiety and self-esteem, Epstein (1985) indicates one of the basic functions of the self is to maintain self-esteem; its increase or decrease can have a direct bearing on an individual's perception of happiness and satisfaction. He further notes anxiety as a state of unpleasant arousal can be constructive or destructive depending on the degree of anxiety experienced and the individual's coping abilities.[16]

A study conducted by Robinson and Frank (1994) sampled 141 males and 172 females of racial diversity, ages 13-19 were surveyed to elicit levels of self-esteem, sexual activity, pregnancy and fatherhood status. Results indicate no significant differences in the levels of self-esteem in relation to race or gender, no significant differences in self-esteem levels of sexually active and non-sexually active females, and no significant differences between virgin females and nonvirgin females.[17] It is imperative for social workers to incorporate and focus attentions on developing a positive self-esteem for adolescents, during this phase in their developmental process, self-esteem is of vital importance for future progression.

Records (1993) conducted a study comparing the life events of pregnant and nonpregnant adolescents, and how the events compared in terms of number and types, and the perception (good or bad) of life events. Results were the nonpregnant group reported a total of 239 life events, the pregnant group, 269 life events. No significant difference was found between groups in terms of their perception of events as good or bad. The pregnant group reported 115 good life events and 154 bad.

---

[16]S. Epstein, "Anxiety, Arousal and the Self-Concept," Issues in Mental Health in Nursing, Vol. 10, (1985), 265.

[17]Rachel B. Robinson and Deborah E. Frank, "The Relation Between Self-Esteem, Sexual Activity and Pregnancy," Adolescence, Vol. 29, No. 113, Spring 1994.

The nonpregnant group reported 108 good life events and 131 bad life events.[18]

Previous research has indicated that certain life events are more prevalent in pregnant adolescents. Another study revealed pregnant adolescents reported the death of a parent, separation from their parents, death of a grandparent, and illness of a parent significantly more than nonpregnant adolescents. This study indicates that change to a new school did differ significantly between groups an its perception was bad for the pregnant group.

Social workers' and health professionals' involvement with pregnant or nonpregnant adolescents requires an understanding of the developmental demands of the adolescent period, awareness that such are stressful and overwhelming, facilitates better communication. Further research to determine life events which may be significant precursors of adolescent pregnancy needs to be undertaken.

Social support involves the presence and products of human relationships. O'Reilly (1988) states it is important that a social network be considered the baseline indicator of social support as it cannot exist without the presence of others.[19]

Literature indicates supportive social networks have been found to exert favorable impact on the course and outcome of adolescent pregnancy (Brown, 1986[20]; Colletta, 1981[21]; Frodi, 1984[22]) as well as on the

---

[18]Kathryn A. Records, "Life Events of Pregnant and Non-Pregnant Adolescents," Adolescence, Vol. 28, No. 110, (Summer 1993).

[19]O'Reilly, (1988) "Methodological Issues in Social Support and Social Network Research," Encyclopedia of Sociology, Vol. 4, Macmillan Publishing Company, (1992), 863-873.

[20]M.A. Brown (1986) "Social Support, Stress, and Health: A Comparison of Expectant Mothers and Fathers" Nursing Research 35, 72-76.

[21]N.D. Colletta (1981) "Social Support and the Risk of Maternal Rejection," Journal of Psychology 109, 191-197.

[22]A. Frodi, "Determinants of Attachment and Mastery Movation in Infants Born to Adolescent Mothers," Infant Mental Health Journal 5, 15-23.

individual's general health. The impact may be especially critical for the pregnant teen facing a multiplicity of stresses with fewer resources available to provide assistance.

Turner, Grindstaff and Phillips (1990) indicate social support has been variously addressed in the literature in terms of social bonds, social network, meaningful social contact, availability of confidantes, and human companionship, as well as social support. The concepts are not identical, each does share a focus on the relevance and significance of human relationships.[23]

Streeter and Franklin indicate that social support is a multidimensional construct assuming many different forms and encompassing a multitude of relationships, behaviors, and consequences. Empirical research has focused on three types of social support: 1) Social Embeddedness; 2) Perceived Social Support; and 3) Enacted Social Support.

Social embeddedness refers to actual connections people have to significant others in their environment. It identifies the direct and indirect linkages that tie people to family, friends, and peers. Perceived social support views support as a cognitive appraisal of one's connections to others. Although the potential exists for a particular relationship to generate expression of support, it is not likely to do so unless it is perceived as available or adequate to meet the need. Efforts to provide support in some cases are inappropriate, poorly timed or against the wishes of the person being helped. Enacted support refers to the specific behaviors or actions performed by others as they exhibit expressions of support and assistance. Enact refers to what

---

[23]R. Jay Turner, Carl F. Grindstaff and Norman Phillips, "Social Support and Outcome in Teenage Pregnancy," Journal of Health and Social Behavior, 1990, Vol. 3, (March): 43-57.

individuals actually do when they provide support (listening, expressing concern, etc.).[24]

Turner, Grindstaff and Phillips (1990) indicated of the three, perceived social support has received the most researchable attention. Consistently, it has shown negative relationships with distress and other adverse health outcomes.[25]

Social embeddedness also tends to be correlated negatively with distress; such relationships have been found to be weaker and are observed less consistently than those with perceived support. Barrera (1986) indicates a number of studies have reported positive association between level of distress and extent of enacted support.[26] Wethington and Kessler (1986), page 85, document that "not only are perceptions of support availability most important than actual support transactions, but that the latter promotes psychological adjustment through the former, as much as by practical resolutions of situational demands.[27]

Literature indicates the hypothesized relevance of social support with respect to pregnancy outcomes can be assessed most effectively with respect to perceived social support. Pattison (1977) identifies two types of support: Instrumental and Affective. Instrumental support addresses tangible forms of support. Affective support includes

---

[24]Calvin L. Streeter and Cynthia Franklin, "Defining and Measuring Social Support: Guidelines for Social Work Practitioners," Research on Social Work Practice, Vol. 2, No. 1, January 1992, 81-98.

[25]R. Jay Turner, Carl F. Grindstaff and Norman Phillips, "Social Support and Outcome in Teenage Pregnancy," Journal of Health and Social Behavior, 1990, Vol. 3, (March): 43-57.

[26]M. Barrera, Jr., "Distinctions Between Social Support Concepts, Measures and Models," American Journal of Community Psychology 14, (1986), 413-416.

[27]Elaine Wethington and Ronald C. Kessler, "Perceived Social Support, Received Support, and Adjustment of Stressful Life Events," Journal of Health and Social Behavior 27, (1986): 78-90.

emotional support (recognition and esteem building).[28] Gottlieb (1978) utilizes explicit description of informal helping behaviors. Twenty six different types, organized into four general modes of support.[29] Emotionally supportive behaviors, problem-solving behaviors, indirect personal influence, and environmental action. Barrera and Ainlay (1983) identifies six categories of social support: 1) Material Aid; 2) Behavioral Assistance; 3) Intimate Interaction which addresses expressing esteem and understanding; 4) Guidance; 5) Feedback; and 6) Positive Social Interaction.[30]

Social support can be derived from various different sources: Informal or Formal. Informal - family, friends, peers, colleagues. Formal - professional helpers. Streeter and Franklin (1992) indicate lack of support from one source is often compensated for by support from other sources. An important distinction has been made between support that is provided informally from friends and family, and that provided through the formal human service system. The distinction generally concerns the extent to which social support spontaneously occurs or is initiated and directed by a professional service delivery system.[31] It is useful to recognize that social support can either be discovered or created, it can occur naturally and be discovered, or it can be invented in an effort to respond to personal crisis or stressful life events.

---

[28]E.M. Pattison, "A Theoretical-Empirical Base for Social Support," E.F. Foulks, R.M. Winthrob, J. Westermeyer, E.A.R. Favazza (eds.), Current Perspectives in Cultural Psychiatrics, New York: Spectrum, 1977, 217-253.

[29]B.H. Gottlieb, "The Development and Application of a Classification Scheme of Informal Helping Behavior," Canadian Journal of Behavioral Science 10, (1978), 105-115.

[30]M. Barrera, Jr. and S.L. Ainlay, "The Structure of Social Support: A Conceptual and Empirical Analysis," Journal of Community Psychology 11, (1983), 133-143.

[31]Calvin L. Streeter and Cynthia Franklin, "Defining and Measuring Social Support: Guidelines for Social Work Practitioners," Research on Social Work Practice, Vol. 2, No. 1, January 1992, 81-98.

Informal support tends to be less structural and deliberate. It can flow from an ongoing personal relationship with family and friends that are enacted when a crisis or need arises.[32]

This study does not directly address adolescent fathers, but it is most imperative to note their significance in relationship to adolescent mothers. Cervera (1991) indicates that in 1987, approximately 500,000 babies were delivered to women 19 years of age and younger, at least 20% to 25% of putative fathers were adolescents. The number of teenage fathers may be underreported because of unwed mothers' reluctance to name the father on birth certificates.[33]

Society and human service personnel for years have neglected and scorned the baby's father (Hendricks, 1980).[34] Literature indicates reported biases due to commonly held beliefs that adolescent fathers are immature, selfish, or withholding emotional or concrete support. In contrast to such attitudes, studies have found adolescent fathers can be very caring and involved persons with the mother and baby (De Anda & Becerra, 1984).[35] According to Barrett and Robinson (1982), some fathers have been found to be "highly motivated to participate in some way in the fathering experience, either in naming the child, providing financial assistance or both.[36] Literature further indicates the baby's father enhances a teenage mother's self worth, sense of maternal

---

[32]Calvin L. Streeter and Cynthia Franklin, "Defining and Measuring Social Support: Guidelines for Social Work Practitioners," Research on Social Work Practice, Vol. 2, No. 1, January 1992, 87.

[33]Neil Cervera, "Unwed Teenage Pregnancy: Family Relationship with the Father of the Baby," Families in Society: The Journal of Contemporary Human Services, Family Service American (1991), 29-37.

[34]L. Hendricks, "Unwed Adolescent Fathers: Problems They face and Their Sources of Social Support," Adolescence 15, (1980), 861-869.

[35]D. De Anda and R.M. Becerra, "Support Networks for Adolescent Mothers," Social Casework 65, (19844), 172-181.

[36]R.L. Barrett and B.E. Robinson, "A Descriptive Study of Teenage Expectant Fathers," Family Relations 31, (1982): 349-352.

competency and attachment to the baby. Cervera (1991) indicates children of involved fathers have better cognitive and social skills than do children whose fathers are absent.[37] In understanding the unwed father's involvement with their babies, it is important to note the attitudes of the adolescent mother and her family. In a study by Barrett and Robinson (1982), results indicate that unwed fathers perceived their girlfriend's family as viewing them positively. However, more often fathers are very likely to face hostile feelings from the unwed mother's family.[38]

In a study conducted by Cervera, of 15 families experiencing an unmarried teenage pregnancy, ages 13 to 19, all were Caucasian and living in intact families. Adolescents and their families were interviewed during and after the pregnancy. Results indicate that family members' closeness to, communication with, and opinions about the baby's father were significantly different as a function of family role and stage of the pregnancy.[39]

Just as older pregnant women do, adolescents need recognition and support from their baby's father. Adolescent mothers, during their pregnancy, may be formally or informally negotiating his role within the family.

Thompson and Peebles-Wilkins indicate in the literature on African American families, researchers are in dispute that informal social networks in the African American community provide economic assistance,

---

[37]Neil Cervera, "Unwed Teenage Pregnancy: Family Relationship with the Father of the Baby," Families in Society: The Journal of Contemporary Human Services, Family Service American (1991), 29-37.

[38]R.L. Barrett and B.E. Robinson, "A Descriptive Study of Teenage Expectant Fathers," Family Relations 31, (1982): 349-352.

[39]Neil Cervera, "Unwed Teenage Pregnancy: Family Relationship with the Father of the Baby," Families in Society: The Journal of Contemporary Human Services, Family Service American (1991), 35.

emotional security and protection from external social forces.[40] Little empirical research is available to inform policy and intervention programs regarding this assumption.

Psychological and emotional health is affected by the transition to motherhood. Significant readjustment in lifestyle, resources and relationships occur that often strain emotional well being. For the adolescent female, the adjustment is further complicated by normal developmental tasks of adolescence (Bacon, 1974).[41]

Literature indicates becoming a mother during adolescence is stressful. Pregnant adolescents whose support networks involved some degree of conflict had higher symptom levels than those without. Social connectedness and embeddedness provide access to social resources and affirmation that increase self-esteem, self-worth and coping capabilities.

In a study by Thompson and Wilkins (1992), examination is given to the mental health of black adolescent mothers to broaden the understanding of the relative importance of different support systems (formal, informal and societal) on the teenagers' general distress, depression and self-esteem. Teens were under age 21, and had delivered their first child during the 12 month period between September 1978 and August 1979. A total of 296 mothers were studied. Results indicate both lay and professional supports were important for the young mother's psychological well-being. Support from a male partner, case worker contact, and membership in a support group decreased psychological distress and depression. Support from the male partner also enhanced psychological well-being (self-esteem). Support from friends, on the

---

[40]Maxine Seaborn Thompson and Wilma Peebles-Wilkins, "The Impact of Formal, Informal and Societal Support Networks on the Pyschological Well-Being of Black Adolescent Mothers," Social Work, Vol. 37, No. 4, July 1992, 322-328.

[41]Ibid., 323.

other hand, was associated with higher levels of psychological distress. A professional service plan that effectively incorporates informal and social supports in a complementary manner, offers the possibility for reducing the distress of black teenage mothers.[42]

In a study by Griffin-Koniak, Lominska and Brecht, they compared similarities and differences in social support among 41 black, 60 hispanic (Mexican American descent) and 60 white pregnant adolescents to determine if support was related to prenatal attachment. 161 pregnant females, under 20 years of age (12 to 19 years), were studied. Results indicate that black pregnant adolescents were found to have significantly lower total functional support scores (emotional and tangible support) than whites. Whites obtained the highest scores followed by hispanics and blacks. Although black adolescents identified the least number of individuals in their social network, the proportion of support provided by family was greatest for this ethnic group. The relationship between social support and prenatal attachment was not found to be significant.[43]

Social support and psychological adjustment during pregnancy was studied in a sample of 157 women by Liese, Snowden and Ford (1989). The study was concerned with "partner status" in addition to social support and psychological adjustment in a predominantly minority sample of low income women. Three subgroups were formulated: married; single/ partnered; single/unpartnered. Results of the study indicated pregnant women who are partnered and those who are not shown important differences in the nature and kind of social support which serves to reduce emotional disequilibrium. Married women benefit most from

---

[42]Maxine Seaborn Thompson and Wilma Peebles-Wilkins, "The Impact of Formal, Informal and Societal Support Networks on the Pyschological Well-Being of Black Adolescent Mothers," Social Work, Vol. 37, No. 4, July 1992, 323.

[43]Deborah Griffin-Koniak, Susan Lominska and Mary Lynn Brecht, "Social Support During Adolescent Pregnancy: A Comparison of Three Ethnic Groups," Journal of Adolescence, Vol. 16, No. 1, 43-56.

instrumental support, especially in the form of shared household task. Unpartnered single women seem to benefit most from expressive social support, as measured by quantity and quality of close friendships, with quality assuming a more important role in reducing levels of psychological distress. Given the relationship between inadequate social support and psychological stress, and pregnancy complications, it is incumbent upon social workers and others responsible for prenatal care to screen for those clients at particular risk in these areas. Utilizing information to determine one's "partnered status."[44]

Turner, Grindstaff and Phillips studied the role and significance of social support for the occurrence of health and birth problems among adolescent mothers and their babies. 268 pregnant teenagers were interviewed during pregnancy and approximately four weeks after delivery. The significance of family support, friend support and partner support, assessed during pregnancy, was examined in relation to infant and mother outcomes at or after birth. Infant outcome was indexed by birth weight, with gestational age controlled; mother outcome in terms of psychological adaptation was indexed by depressive symptomatology among adolescent mothers. Results indicate most plausibly the significance of family emotional support and intimacy for the health and well-being of both teenage mothers and their offspring.[45]

A myriad of programs and services have been developed to meet the identified needs of pregnant and parenting adolescents. Many adolescents appear reluctant to use the health and social services designed especially for them. Research, however, points to the importance of support from significant others, especially maternal

---

[44]Lawrence H. Liese, Lonnie R. Snowden and Lucy K. Ford, "Partner Status, Social Support and Psychological Adjustment During Pregnancy," Family Relations, No. 36, (July 1989), 311-316.

[45]R. Jay Turner, Carl F. Grindstaff and Norman Phillips, "Social Support and Outcome in Teenage Pregnancy," Journal of Health and Social Behavior, 1990, Vol. 3, (March): 43-57.

grandparents, in reducing the risk of physical, social and cognitive deficits in children of adolescent mothers (parents). Therefore, the availability and use of informal support systems appear to be of vital significance in influencing outcomes for pregnant and parenting adolescents.

The majority of pregnant teenagers do not use formal support systems. Although access and stigma may be significant deterrents to use of services, this study by Bergman points out the importance of informal support networks for pregnant adolescents.[46] The focus was nonmedical prenatal service utilization for fifty-four primiporous adolescent mothers, ages 15-19. Results indicate the study group did not differ significantly from pregnant adolescents described in other studies, nor did they differ in many ways from non-pregnant adolescents. In terms of formal source of support, 68% used at least one specialized nonmedical prenatal service during their pregnancy. Prenatal classes were most used (57%), followed by education programs (30%), pregnancy counseling (25%) and teen groups (24%). Regarding informal sources of support, (69%) described an independent network orientation; that is they had few close ties with their family and friends. Respondents identified their most significant helpers as parents (33%), followed by husbands/boyfriends, girlfriends and relatives.[47]

Social workers must not overlook the importance of boyfriends to pregnant adolescents, nor the utilization of informal support systems as primary helpers to pregnant adolescents, nor neglect the importance of formal support sytems. Support needs to be given in the forms of emotional assistance, financial, referral and assistance as specified by

---

[46]Ann G. Bergman, "Informal Support Systems for Pregnant Teenagers," Social Casework: The Journal of Contemporary Social Work, (November 1989), 525-533.

[47]Ibid., 525.

each social network. The family is normally attempting to handle the crisis with limited resources or inadequate resources.[48]

Theoretical Framework

The theoretical framework that inform this study are Erikson's Theory of Identity Versus Role Confusion, and Bronnfenbrenner Ecological Perspective. Erikson's discussion of identity versus role confusion emphasizes the conflict adolescents are facing in their efforts to establish clear ideas about their values, objectives, and place in life. Lack of clarity regarding how to fit into the social environment formulates identity crisis.[49]

Erikson thought as identity formation continues throughout one's life, identity "has its normative crisis in adolescence." This identity is established through the individual's psychological integration and social environment. Searching for self-identity, conflicts arise between the adolescent and his or her parents as a necessary movement toward establishing the adolescent's own view of self, of the world, and one's place in that world.[50]

The ecological perspective represents a philosophical conception of human beings as active, purposeful and having potential for growth, development and learning throughout the life cycle (Gibbs and Huang, 1989).[51] The adolescent is embedded into circular context; including the microsystem, mesosystem and interpersonal relations, the exosystem or social structure, institutions, and the macrosystem or overarching

---

[48]Ann G. Bergman, "Informal Support Systems for Pregnant Teenagers," Social Casework: The Journal of Contemporary Soical Work, (November 1989), 525.

[49]Robert L. Barber, Social Work Dictionary, 2nd edition. National Association of Social Workers, Washington, D.C. (1991), 108.

[50]Encyclopedia of Social Work, Vol. I, (1987), 54.

[51]Jewell Taylor Gibbs, Huang Larke Nahme and Associates, Children of Color, San Francisco: Jossey-Bass Publishers, 1989.

cultural patterns, values and ideologies. The adolescent is often in conflict in his attempt to establish values, norms, and behaviors as a means of socialization, as each environmental context is recognized to have potential effects on health and illness.

Definition of Terms

Adolescence - A period in the life cycle between childhood and adulthood.

Adolescent - A person who is 13 years of age or older, but under the age of 18.

African American - Americans of African descent. Black and African American may be used interchangeably in the study.

Teenage Pregnancy - A pregnancy which occurs between the ages of 13 and 19 years of age.

Anxiety - A feeling of uneasiness, tension and sense of imminent danger.

Self-Esteem - An individual's sense of personal worth that is derived more from inner thoughts and values than from praise and recognition from others.

Significance - Having or likely to have a major effect.

Pregnancy - The reproductive state of carrying a fetus within the body; that is the time between conception and birth.

Social Support - The provision of resources (emotional, formal/informal, or tangible) by others (social network) to an individual who is experiencing some level of difficulty.

Statement of the Hypothesis

There is no statistical significant relationship between self esteem, anxiety and social support on teen pregnancy.

CHAPTER III
METHODOLOGY

Research Design

This is an exploratory, descriptive study intended to examine the perceived impact of self-esteem, anxiety, and social support on teen pregnancy. It will determine if there are significant relationships between self-esteem, anxiety and social support on adolescent pregnancy.

Sampling

A non probability convenience sample was selected from participants in a local Pregnancy and Adoption Unit of a Family Service Community Agency in Atlanta, Georgia. The study was designed for forty-six females between the ages of 13 and 19. All participants were pregnant at the start of the study, several delivered their babies while the study was being conducted. All participants voluntarily agreed to complete the 38 item questionnaires, and each met the criteria of having or having had a confirmed pregnancy.

Data Collection Procedure/(Instrumentation)

The data for this study was obtained through interviews with participants using a structured questionnaire. Before administering the questionnaire, preliminary tasks were completed. The researcher obtained authorization to utilize participants ages 13-19 from the Pregnancy Adoption Unit, Outreach Programs and Bell Hall of a Family Service Agency. The researcher was introduced and the purpose and goals of the study were stated. Confidentiality and anonymity were ensured, and parental consent was obtained for participants ages seventeen (17) and under. From the sample, identified persons were given the option to

refuse participation in the study. Participants who agreed to participate signed a consent form.

Clear instructions for completing the questionnaire were provided. Time was allocated for questions and answers. The questionnaire took approximately 20 minutes to complete.

This 38 item instrument was adopted from Walter W. Hudson (1992), Index of Self-Esteem, Bruce A. Thyer (1992), Clinical Anxiety Scale and Gregory D. Zimet, Nancy W. Dahlem, Sara G. Zimet and Gordon K. Farley (1988), Multidimensional Scale of Perceived Social Support.

The researcher utilized 8 demographic items, 10 self-esteem items, 10 anxiety items and 10 social support items. The reliability and validity of this instrument is not known, as the researcher utilized portions from each scale. There is a need for additional testing and refinement.

Walter W. Hudson's Index of Self-Esteem is a 25 item scale designed to measure problems with self-esteem. It measures the degree, severity or magnitude of a problem one has with self-esteem.

This scale was administered to 1,745 single and married individuals, clinical and non-clinical population, college students and non-students. Reliability of this Index of Self-Esteem (ISE) has a mean alpha of .93. The validity has good known groups validity significantly distinguishing between clients judged by clinicians to have problems in the area of self-esteem and those judged not so.[1]

Bruce Thyer's Clinical Anxiety Scale is a 25 item scale that measures amount, degree, or severity of clinical anxiety. The initial administration of the Clinical Anxiety Scale (CAS) was on 41 women and 6 men from an agoraphobic support group, 51 men and 32 women from the United States Army, and 58 female and 15 male university students. Reliability of this CAS has excellent internal consistency with a

---

[1]Walter W. Hudson, The WALMYR Assessment Scales Scoring Manual, (1992), Tempe, Arizona: WALMYR Publishing Company.

coefficient alpha of .94. Clinical Anxiety Scale has good known groups validity, discriminating significantly between groups known to be suffering from anxiety and lower anxiety control groups.[2]

Clinical Anxiety Scale and Index of Self-Esteem are scored by reverse scoring method. Multidimensional Scale of Perceived Social Support by Gregory D. Zimet, Nancy W. Dahlem, Sara G. Zimet and Gordon K. Farley is a 12 item instrument designed to measure perceived social support from family, friends, and significant others. The Multidimensional Scale of Perceived Social Support has been studied with a variety of diverse samples. The study utilized 154 students in a two or four-year college on a large urban campus. It has excellent internal consistency and reliability with alphas of .91 for total scale and .90 and .95 for subscales. The validity has good factorial validity and good concurrent validity. It is scored by summing individual items scores and dividing by the number of items.[3]

Data Analysis

The collected data was coded on the SPSS system at the Clark Atlanta University Center. The method of analysis was through descriptive statistics including percentages, frequency distribution and correlation coefficient (Pearson r), which is an index of the strength and direction of linear association between two variables. Correlations range between -1 and +1. A negative correlation means that as the value of one variable increases, the value of the other variable decreases. A correlation of -.70 is considered as strong as one of +.70 Positive or negative signs in front of the correlation indicates only the direction of the relationship.

---

[2]Walter W. Hudson, The WALMYR Assessment Scales Scoring Manual, (1992), Tempe, Arizona: WALMYR Publishing Company.

[3]G.D. Zimet, N.W. Dahlem, S.G. Zimet and G.K. Farley, "The Multidimensional Scale of Perceived Social Support," Journal of Personality Assessment, (1988), 52:30-41.

CHAPTER IV

PRESENTATION OF RESULTS

Null Hypothesis:

There is no statistical significant relationships between self esteem, anxiety, and social support on teen pregnancy.

To test for the Null Hypothesis bivariate analysis was computed using Pearson (r). The results of the analysis are seen on table 12. Based on these findings, the Null Hypothesis was rejected; there is a statistical significant relationship between self-esteem, anxiety, and social support.

The objectives of the study was to examine the perceived impact of self-esteem, anxiety and social support on teen pregnancy.

In particular, the purpose of this investigative research was to obtain information regarding the significant relationships between self-esteem, anxiety and social support on adolescent pregnancy.

The responses of 44 African American adolescent females, one Hispanic adolescent female and one Native American adolescent female were utilized to comprise the data of this study. The research questionnaire contained 38 items.

Table 1
Age of Teens

n = 46

Age	Frequencies	Percentages
15	7	15.21
16	6	13.0
17	15	32.6
18	12	26.0
19	6	13.0

Table 1 addresses the question, "What is your age?" Of the 46 adolescent females studies, 15.21% were fifteen years old; 13% were sixteen years old; 32.6% were seventeen years old; 26% were eighteen years old; and 13% were nineteen years old.

Table 2
Grade

Grade	Frequencies	Percentages
8th	3	6.5
9th	9	19.5
10th	11	23.9
11th	19	41.0
12th	4	8.6

Table 2 addresses the question, "What was the last grade you completed?" Of the adolescent female respondents, 6.5% completed the eighth grade; 19.5% completed the ninth grade; 23.9% completed the tenth grade; 41.0% completed the eleventh grade; and 8.6% completed the twelfth grade.

Table 3
Race

Race	Frequencies	Percentages
African American	44	95.6
Hispanic	1	2.0
Other (Specify)	1	2.0

Table 3 addresses the question, "What is your race?" The majority of the adolescent female respondents, 95.6%, were African American; 2% were Hispanic and 2% were Native American.

Table 4
Income

Income	Frequencies	Percentages
5,000 - 10,000	8	17.0
11,000 - 20,000	10	21.7
21,000 - 30,000	9	19.5
31,000 - 40,000	5	10.8
Over 40,000	2	4.0
Parent Unemployed On Welfare (SSI)	12	26.0

Table 4 addresses the estimated income of parents. Of the respondents' estimated income of their parents, 17.0% reported income between 5,000 - 10,000; 21.7% reported income between 11,000 - 20,000; 19.5% reported income between 21,000 - 30,000; 10.8% reported income between 31,000 - 40,000; 4.0% reported income over 40,000; and 26.0% reported that parents were unemployed on welfare (SSI).

Table 5
With Whom Do You Live?

Living Arrangements	Frequencies	Percentages
Parents (mother & father)	9	19.5
Grandparents	3	6.5
Mother Only	26	56.5
Father Only	1	2.0
Relatives	4	8.6
Other (Specify)	3	6.5

Table 5 addresses the question, "With whom do you live?" The respondents indicated that 19.5% live with their parents (mother & father); 6.5% live with their grandparents; 56.5% live with their mother only; 2.0% live with their father only; 8.6% live with relatives; and of the category other, 6.5%, one lives with her husband and parents, and two live alone.

Table 6
Religious Preference

Religious Preference	Frequencies	Percentages
Baptist	30	65.0
Catholic	4	8.6
Non-Denominational	1	2.0
Jehovah Witness	2	4.0
Methodist	3	6.5
None	6	13.0

Table 6 addresses the question, "What is your religious preference?" Sixty-five percent of the adolescent female respondents indicated Baptist was their religious preference; 8.6% indicated Catholic was their religious preference; 2.0% indicated non-denominational; 4.0% indicated Jehovah Witness; 6.5% Methodist; and 13.0% did not indicate a religious preference.

Table 7
Have You Ever Been Pregnant?

Ever Been Pregnant	Frequencies	Percentages
Yes	37	80.4
No	9	19.5

Table 7 addresses the question, "Have you ever been pregnant?" Eighty and four-tenths percent of the adolescent female respondents indicated they had been pregnant; 19.5% indicating they had not ever been pregnant.

Table 8
Are You Pregnant Now?

Now Pregnant	Frequencies	Percentages
Yes	14	30.4
No	32	69.5

Table 8 addresses the question, "Are you pregnant now?" Of the adolescent female respondents in the study, 30.4% indicate they are now pregnant; 69.5% indicate they are not pregnant now.

Part II - Self Esteem

Table 9
Self-Esteem Measurement

Self-Esteem	Frequencies	Percentages
Low (less than 56)	20	43.4
Moderate (56-62)	14	30.4
High (63-70)	12	26.0

Table 9 indicates that of the adolescent female respondents studied, 43.4% have low self-esteem; 30.4% have moderate self-esteem; and 26.0% have high self-esteem.

See Appendix E for additional tables 13-22 on self-esteem.

Part III - Anxiety

Table 10
Clinical Anxiety Measurement

Anxiety	Frequencies	Percentages
Low (less than 40)	25	54.3
Moderate (40-44)	10	21.7
High (45-50)	11	23.9

Table 10 indicates that of the adolescent female respondents studied, 54.3% have a low degree of clinical anxiety; 21.7% have a moderate degree of clinical anxiety; and 23.9% have a high degree of clinical anxiety.

See Appendix E for additional tables 23-32 On Clinical Anxiety.

Part IV - Social Support

Table 11
Perceived Social Support Measurement

Perceived Social Support	Frequencies	Percentages
Low (less than 56)	21	45.6
Moderate (56-62)	14	30.4
High (63-70)	11	23.9

Table 11 indicates that of the adolescent female respondents studied, 45.6% have low perceived social support from family, friends and significant others; 30.4% have moderate perceived social support from family, friends and significant others; and 23.9% have high perceived social support from family, friends and significant others.

See Appendix E for additional tables 33-42 on Perceived Social Support.

Table 12
Correlation Coefficient Between
Anxiety, Social Support and Self-Esteem

Variable	Pearson r	Percentages
Anxiety	.6648	.000 *
Social Support	.4172	.004

* Statistical Significant

CHAPTER V

SUMMARY AND CONCLUSION

The questionnaire was designed to assess the level of self-esteem, anxiety and social support on teen pregnancy.

The Null Hypothesis, which states, "There is no statistical significant relationship between self-esteem, anxiety and social support on teen pregnancy," was rejected.

The sample group self-esteem scores ranged from 56 to 70. The score of the subjects in this study indicated 43.4% of the pregnant teens classified in the low self-esteem category, 30.4% in moderate, and 26.0% in high self-esteem.

The anxiety scores for the sample of pregnant teens were low anxiety 54.3%, moderate 21.7%, and high anxiety was 23.9%. Bivariate analysis revealed significant differences between anxiety scores and self-esteem.

The social support scores of the subjects were 45.6% low, 30.4% moderate, and 23.9% high. Bivariate analysis was used for the variables anxiety and social support. Pearson r results for anxiety was .6648, and for social support .4172. There was a statistical significant relationship at .004.

The results of this study are indeed intellectually alarming. It brings to consciousness the dramatic emotional impact adolescent s face as a result of being pregnant or having experienced a pregnancy during the teen years.

It illustrates how significantly important self-esteem, anxiety, and social support are to the adolescent female, and how anxiety and perceived social support are critically essential during the developmental years of an adolescent's life. Inability to connect adequately and appropriately to social supports can lead to low self

esteem, high levels of anxiety, and could possibly hinder on-going relationships with parents, immediate and extended family, peers, and significant others in one's social network.

The study is not unlike the study done by Koniak-Griffin, Lominska, and Brecht regarding social support during adolescent pregnancy, of three ethnic groups. Their findings show, as does this study, that variations in social support received by a pregnant teen can provide life stresses and that social support is related to prenatal emotional disequilibrium.

The majority of the respondents were African American adolescent females, ages 15 to 19. These are crucial ages of developmental functioning. African American females face numerous obstacles; pregnancy only compounds these obstacles.

The study also found a significant number of African American females reside with only their mothers, followed by a two parent household. Other studies have similarly found this outcome. According to the 1980 census, there is a heavy representation of single mother headed households. This study illustrates such findings.

Most significantly in terms of these findings was that 80.4% of these pregnant teens have been pregnant before and this pregnancy is not their first. At least 30.4 percent are now pregnant. This information is vital as it emphasizes and reiterates the importance of social support from family, friends and significant others, and the importance of securing appropriate medical services to reduce high degrees of anxiety. It also illustrates the need to increasingly educate adolescent females and males, and provide the necessary assistance to increase their understanding of human sexuality so they can make responsible decisions regarding subsequent pregnancies.

The study finds a significantly large majority of respondents indicated low self-esteem (see Table 9); also a significantly large

majority indicated a low degree of anxiety (see Table 10); also a low degree of perceived social support (see Table 11).

The above findings are most alarming. This researcher questions what leads to such low degrees in all three variables. Can one truly analyze the magnitude of such findings? This researcher questions to what degree these findings will threaten the future generations of adolescent African American females, and their offspring.

Literature suggests persuading teens to postpone childbearing either by convincing them of the virtues of chastity or by making abortion, sex education, and contraception more freely available. However, there are those in our society who strongly disagree with such suggestions, and teens are continuing to become pregnant. Other studies also indicate African American teens who are inheritability disadvantaged are likely to become pregnant and give birth outside of marriage. Those who are not disadvantaged are discouraged from becoming pregnant. Other troubles, such as one not doing well in school, lower measured ability, and lacks high aspirations for herself, also place a teen at risk of becoming a teenage mother. Studies also indicate a poor, Black teenager from a female-headed household who scores low on standardized tests has a one in four chance of becoming an unwed mother in her teens. Her white counterpart has one chance in twelve.

The variables analyzed in this study collectively are the necessary building blocks for pregnant and non-pregnant adolescents. Adolescents who have chosen to experiment with intercourse and do not utilize appropriate measures will most likely experience an unintended pregnancy. Adolescent mothers face pronounced increases in emotional, social and physical consequences as a result of early childbearing.

Adolescents need knowledge, guidance and encouragement to facilitate stable emotional growth and the building of self-esteem, reduction of anxiety and continue the establishment of social support.

Limitations of the Study

Due to the convenience sample population, the researcher will not generalize findings to the total population. The researcher can only state that the results can be applied to this sample group. Additionally, the instrument utilized points the way to future questionnaires.

Suggested Research Directions

Replicating this study within a larger population would benefit professionals on the federal, state and local levels. Studies should include additional questions relating to cultural attitudes, values and beliefs. Analyzing existing teen pregnancy programs, educational systems and social support networks would be beneficial for future research. Also indepth studies analyzing the economical structure and household makeup of a teen's family would be most beneficial.

A follow-up study should be conducted to re-examine the adolescents perceived impact of self-esteem, anxiety and social support, especially to African American adolescents.

A comparative study should be conducted on adolescent fathers utilizing the variables in this study.

CHAPTER VI

IMPLICATIONS FOR SOCIAL WORK

This research is directed towards examining the perceived impact of self-esteem, anxiety and social support on adolescent pregnancy, and to obtain information regarding the significant relationships.

Solutions to this social phenomenon of teen pregnancy continues to exist as there are gaps in social work knowledge in terms of empirical findings that addresses self-esteem, anxiety, and social support, and its impact and significance on adolescent pregnancy.

This problem contributes to social work knowledge, theory and practice on several levels.

Erikson's Theory of Identity Versus Role Confusion adequately supports and emphasizes the conflicts adolescents face in their attempt to establish clear ideas about who they are and their face in society.

Bronnfenbrenner's Ecological Perspective clearly illustrates the pregnant adolescent's lack of clarity regarding how to fit into the social environment as they face the internal and external forces of their social environment.

Research indicates that over one million American adolescents become pregnant each year. This figure translates into approximately one in every nine adolescent females every year.

Research also indicates that adolescent pregnancy presents a significantly disproportionate economical and social burden to society. The President of the United States has called teenage pregnancy "our most serious social problem." It is such a social problem that currently there exists a national debate over welfare reform within the United States Congress, over a fundamental question: How to bring down the high number of births to unwed teenage mothers by rewriting federal

welfare regulations to deny Aid to Families with Dependent Children (AFDC) to unwed mothers under 18 year of age.

This study's findings indicate 80.4 percent of the adolescents between the ages of fifteen and nineteen have experienced pregnancy and 30.4 percent are now pregnant. It is significant to note that 19.5 percent have never been pregnant, and most significantly, 69.5% are not currently pregnant.

In view of such political turbulence, social workers, organizationally and individually, will need to systematically examine the implications, depth, magnitude and consequences policy proposal will have on adolescent pregnancy.

Social workers will need to advocate alternatives to such policies; alternatives that will provide maximum economical stability for pregnant adolescents and their children. Advocate, not only on the federal level but also on the state and local levels, policies and programs that can improve the educational, psychological, social and environmental well being. Advocate for family planning programs which would give the poorer teens the same option as the wealthy; to choose children at a later stage in life and when they are wanted; sex education programs starting in elementary school, taught on levels that younger children can understand. School Base Adolescent Health Care Programs to better access contraceptives, and the understanding of how they are to be appropriately utilized. There is not a quick fix to the teen pregnancy problem, however, services of this nature can have a significant impact.

This study's findings indicate 43.4 percent of the African American respondents indicate low self-esteem, 30.4 percent moderate self-esteem, and 26.0 percent high self-esteem. Respondents indicate 54.3 percent low anxiety, 21.7 percent moderate anxiety, and 23.9 percent high anxiety. As for perceived social support, respondents indicate 45.6 percent low, 30.4 percent moderate, and 23.9 percent high.

The findings significantly indicate the increased need for interventions addressing the above stated variables.

Social workers must remain cognizant and sensitive to the fact that adolescent parenthood greatly increases the likelihood of negative life outcomes for both adolescent mothers and their children. Evidence shows that especially when families are poor, the larger the number of children born, and the more close together they are born, the greater the chances of adverse outcomes, thus the implication for programs advocating family planning.

Adolescence is a time of transition; one in which realistic and appropriate choices and expectations need guidance in becoming reality. Research indicates the most fundamental reason for high rate of school age pregnancy in the United States is that too many youngsters are reaching adolescence without hopes or plans for a future that seems compelling enough to deter them from early parenthood. It is important that social workers play a significant role in the attainment of these goals by providing ego strengthening and self-esteem building, to lower levels of anxiety and increase perceived levels of social support.

In planning support groups for this population, an important goal becomes one of reducing anxiety to a level where problem solving can occur. In addition, self-esteem can be enhanced by introducing new ways of thinking about oneself, supplying new information and increasing coping skills. These measures include the use of relaxation techniques and consciousness raising in regards to personal rights and choices.

Support for independent choice in the decision to have and keep their babies and reinforcement of positive contributions to others in the group through sharing knowledge, encouragement, and leadership, contribute to self-esteem. Finally, encouragement to recognize negative personal statements and change them to positive assertive self statements is important in helping pregnant teens to internalize a different, more positive sense of herself.

Social workers must make a realistic commitment to improving the life prospects of adolescents. By assisting the pregnant and parenting adolescent in the facilitation of appropriate and expanded job opportunities, improved prenatal and postnatal child health care services, to strengthen family functioning and social support, and placing much greater emphasis on the development of competence and prevention of academic failure through high quality child care and preschool programs and changes in schools to heighten the chances that high-risk adolescents will delay pregnancy and succeed in school.

CLARK ATLANTA UNIVERSITY

School of Social Work

February 24, 1995

Mrs. Patricia Showell
Assistant Executive Director
Families First
1105 West Peachtree Street, N.W.
Atlanta, Georgia 30357

Dear Mrs. Showell,

I am interested in conducting a study of the significance of self-esteem, anxiety and social support on pregnant teens. I am requesting your permission to utilize clients, ages 13-19, from the Pregnancy Adoption Unit, Bell Hall and outreach programs.

Confidentiality and anonymity will be assured. Families First will be provided with copies of the questionnaire and results of the study upon request.

If you have any questions, please contact me or my thesis advisor, Professor Hattie Mitchell at Clark Atlanta University at 880-8555/6739.

Thank you, in advance, for your support and cooperation.

Sincerely,

Velma M. Tyler
Graduate Student
CAU School of Social Work

Prof. Hattie Mitchell
Thesis Advisor

VMT/HM

CLARK ATLANTA UNIVERSITY

School of Social Work

February 25, 1995

Dear Participant:

My name is Velma M. Tyler. I am a graduate student at Clark Atlanta University School of Social Work. I am conducting a study designed to examine the impact and significance of factors such as self-esteem, anxiety and social support as perceived by pregnant teens.

Please assist me by completing the following questionnaire. It will take approximately twenty minutes to answer the questions. Your participation is strictly voluntary. Your responses will be totally confidential and your name will not appear on the questionnaire.

If you have any questions regarding this study, please feel free to ask at any time.

If you understand all of the above statements and agree to participate in this study, please sign below.

Thank you for your cooperation.

Sincerely,

Velma M. Tyler

Velma M. Tyler, Graduate Student
CAU School of Social Work

Hattie Mitchell

Prof. Hattie Mitchell
Thesis Advisor

VMT/HM

Participant's Signature _____ Date _____

APPENDIX C

CLARK ATLANTA UNIVERSITY

School of Social Work

February 24, 1995

Dear Parent(s):

My name is Velma M. Tyler. I am a graduate student at Clark Atlanta University School of Social Work. I am conducting an exploratory, descriptive study designed to examine the impact and significance of factors such as self-esteem, anxiety and social support as perceived by those teens who previously delivered and pregnant teens.

I am asking permission for your daughter's participation in this study. Confidentiality and anonymity will be assured. Your daughter's name will not appear on the questionnaire. Please indicate your response on the bottom of this letter, then detach and give your response to the Families First social worker.

If you have any questions regarding this survey, you may contact me through my thesis advisor's office at Clark Atlanta University, 880-8555/6739.

Thank you for your assistance and cooperation.

Sincerely,

Velma M. Tyler

Velma M. Tyler, Graduate Student
CAU School of Social Work

Hattie Mitchell

Prof. Hattie Mitchell
Thesis Advisor

VMT/HM

----------Tear Here----------

I consent ___ I do not consent ___ for my daughter, _____ to participate in this study designed to examine the impact and significance of factors such as self-esteem, anxiety and social support on teen pregnancy.

_____ _____
Parent's Signature Date

_____
Daughter's Name

APPENDIX D

Thank you for participating in this research study. To insure confidentiality, DO NOT PUT YOUR NAME on the questionnaire. Please answer each question as carefully and accurately as possible.

PART I. DEMOGRAPHIC INFORMATION

Please fill in or circle the appropriate response.

1. What is your age? _____

2. What was the last grade you completed? _____

3. What is your race?
   1) African American
   2) White
   3) Hispanic
   4) Other (specify)
   _____

4. Estimated income of parents?
   1) $ 5,000 - $10,000
   2) $11,000 - $20,000
   3) $21,000 - $30,000
   4) $31,000 - $40,000
   5) Over $40,000
   6) Parent unemployed on welfare (SSI, AFDC)

5. With whom do you live?
   1) Parents (Mother and Father)
   2) Grandparents
   3) Mother only
   4) Father only
   5) Relatives
   6) Other (specify)
   _____

6. What is your religious preference? _____

7. Have you ever been pregnant?
   1) Yes
   2) No

8. Are you pregnant now?
   1) Yes
   2) No

PART II. SELF-ESTEEM ITEMS

Please answer each item as carefully and as accurately as you can by placing the appropriate number beside each one as follows:

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. _____ I feel that people would not like me if they really knew me well.
2. _____ I feel that I am a beautiful person.
3. _____ I feel that I am a very competent person.
4. _____ I feel that I need more self-confidence.
5. _____ I think I am a dull person.
6. _____ I feel ugly.
7. _____ I feel very self-conscious when I am with strangers.
8. _____ I feel that if I could be more like other people I would have it made.
9. _____ I feel I get pushed around more than others.
10. _____ I am afraid I will appear foolish to others.

PART III. ANXIETY SCALE ITEMS

Please answer each item as carefully and as accurately as you can by placing the appropriate number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most or all of the time

1. _____ I feel calm.
2. _____ I feel tense.
3. _____ I feel nervous.
4. _____ I feel confident about the future.
5. _____ I feel relaxed and in control of myself.
6. _____ I feel nervousness or shakiness inside.
7. _____ I get upset or feel panicky unexpectedly.
8. _____ I feel generally anxious.
9. _____ I have spells of terror or panic.
10. _____ I feel afraid without good reason.

PART IV. SOCIAL SUPPORT ITEMS

Please answer each item as carefully and as accurately as you can by placing the appropriate number beside each one as follows:

1 = Very strongly disagree
2 = Strongly disagree
3 = Mildly disagree
4 = Neutral
5 = Mildly agree
6 = Strongly agree
7 = Very strongly agree

1. _____ My family tries to help me.

2. _____ I get the emotional help and support I need from my family.

3. _____ There is a special person (boyfriend) who is around when I am in need.

4. _____ There is a special person with whom I can share joys and sorrows.

5. _____ My friends really try to help me.

6. _____ I can count on my friends when things go wrong.

7. _____ I can talk about my problems with my family.

8. _____ My family is willing to help me make decisions.

9. _____ I have a special person who is a real source of comfort to me.

10. _____ There is a special person in my life who cares about my feelings.

Adopted from Hudson, Walter W. (1992) The WALMYR Assessment Scales Scoring Manual. Tempe, AZ; WALMYR Publishing Co. and Zimet, G.D., Dahlem, N.W., Zimet, S.G. and Farley, G.K. (1988) The Multidimensional Scale of Perceived Social Support, Journal of Personality.

APPENDIX E

Part II. Self Esteem Items

Table 13 N = 46

Question 1. I feel that people would not like me if they really knew me well.

Responses	Frequencies	Percentages
1 = None of the time	26	56.5
2 = Very rarely	8	17.0
3 = A little of the time	4	8.6
4 = Some of the time	4	8.6
5 = A good part of the time	1	2.0
6 = Most of the time	1	2.0
7 = All of the time	1	2.0
TOTAL	46	96.7

Table 14 N = 46

Question 2. I feel that I am a beautiful person.

Responses	Frequencies	Percentages
1 = None of the time	3	6.5
2 = Very rarely	0	0.0
3 = A little of the time	1	2.0
4 = Some of the time	6	13.0
5 = A good part of the time	4	8.6
6 = Most of the time	12	26.0
7 = All of the time	20	43.4
TOTAL	46	99.5

Table 15 N = 46

Question 3. I feel that I am a very competent person.

Responses	Frequencies	Percentages
1 = None of the time	3	6.5
2 = Very rarely	1	2.0
3 = A little of the time	6	13.0
4 = Some of the time	9	19.5
5 = A good part of the time	8	17.0
6 = Most of the time	5	10.8
7 = All of the time	14	30.0
TOTAL	46	98.8

Table 16 N = 46

Question 4. I feel that I need more self confidence.

Responses	Frequencies	Percentages
1 = None of the time	10	21.7
2 = Very rarely	6	13.0
3 = A little of the time	5	10.8
4 = Some of the time	15	32.6
5 = A good part of the time	2	4.0
6 = Most of the time	6	13.0
7 = All of the time	2	4.0
TOTAL	46	99.1

Table 17 N = 46

Question 5. I think I am a dull person.

Responses	Frequencies	Percentages
1 = None of the time	26	56.5
2 = Very rarely	9	19.5
3 = A little of the time	5	10.8
4 = Some of the time	5	10.8
5 = A good part of the time	0	0.0
6 = Most of the time	0	0.0
7 = All of the time	1	2.0
TOTAL	46	99.6

Table 18 N = 46

Question 6. I feel ugly.

Responses	Frequencies	Percentages
1 = None of the time	24	52.2
2 = Very rarely	11	23.9
3 = A little of the time	4	8.6
4 = Some of the time	5	10.8
5 = A good part of the time	0	0.0
6 = Most of the time	0	00.0
7 = All of the time	2	4.0
TOTAL	46	99.5

Table 19 N = 46

Question 7. I feel very self conscious when I am with strangers.

Responses	Frequencies	Percentages
1 = None of the time	9	19.5
2 = Very rarely	10	21.7
3 = A little of the time	5	10.8
4 = Some of the time	12	26.0
5 = A good part of the time	2	4.0
6 = Most of the time	2	4.0
7 = All of the time	6	13.0
TOTAL	46	99.0

Table 20 N = 46

Question 8. I feel that if I could be more like other people I would have it made.

Responses	Frequencies	Percentages
1 = None of the time	20	43.4
2 = Very rarely	11	23.9
3 = A little of the time	2	4.0
4 = Some of the time	8	17.0
5 = A good part of the time	3	6.5
6 = Most of the time	0	0.0
7 = All of the time	2	4.0
TOTAL	46	98.8

Table 21 N = 46

Question 9. I feel that I get pushed around more than others.

Responses	Frequencies	Percentages
1 = None of the time	23	50.0
2 = Very rarely	8	17.0
3 = A little of the time	5	10.8
4 = Some of the time	6	13.0
5 = A good part of the time	2	4.0
6 = Most of the time	2	4.0
7 = All of the time	0	0.0
TOTAL	46	98.8

Table 22 N = 46

Question 10. I am afraid that I will appear foolish to others.

Responses	Frequencies	Percentages
1 = None of the time	21	45.6
2 = Very rarely	6	13.0
3 = A little of the time	5	10.8
4 = Some of the time	7	15.21
5 = A good part of the time	2	4.0
6 = Most of the time	0	0.0
7 = All of the time	5	10.8
TOTAL	46	99.41

Part III - Anxiety Scale Items

Table 23 N = 46

Question 1. I feel calm.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	1	2.0
2 = A little of the time	2	4.0
3 = Some of the time	14	30.4
4 = A good part of the time	7	15.21
5 = Most or all of the time	22	47.8
TOTAL	46	99.41

Table 24 N = 46

Question 2. I feel tense.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	8	17.0
2 = A little of the time	12	26.0
3 = Some of the time	19	41.0
4 = A good part of the time	4	8.6
5 = Most or all of the time	3	6.5
TOTAL	46	99.1

Table 25 N = 46

Question 3. I feel nervous.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	8	17.0
2 = A little of the time	17	36.9
3 = Some of the time	11	23.9
4 = A good part of the time	6	13.0
5 = Most or all of the time	4	8.6
TOTAL	46	99.4

Table 26 N = 46

Question 4. I feel confident about the future.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	3	6.5
2 = A little of the time	5	10.8
3 = Some of the time	11	23.9
4 = A good part of the time	11	23.9
5 = Most or all of the time	16	34.7
TOTAL	46	99.8

Table 27 N = 46

Question 5. I feel relaxed and in control of myself.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	1	2.0
2 = A little of the time	3	6.5
3 = Some of the time	12	26.0
4 = A good part of the time	10	21.7
5 = Most or all of the time	20	43.4
TOTAL	46	99.6

Table 28 N = 46

Question 6. I feel nervousness or shakiness inside.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	16	34.7
2 = A little of the time	15	32.6
3 = Some of the time	10	21.7
4 = A good part of the time	2	4.0
5 = Most or all of the time	3	6.5
TOTAL	46	99.5

Table 29 N = 46

Question 7. I get upset or feel panicky unexpectedly.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	21	45.6
2 = A little of the time	13	28.2
3 = Some of the time	9	19.5
4 = A good part of the time	2	4.0
5 = Most or all of the time	1	2.0
TOTAL	46	99.3

Table 30 N = 46

Question 8. I feel generally anxious.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	11	23.9
2 = A little of the time	15	32.6
3 = Some of the time	6	13.0
4 = A good part of the time	8	17.0
5 = Most or all of the time	6	13.0
TOTAL	46	99.5

Table 31 N = 46

Question 9. I have spells of terror or panic.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	33	71.7
2 = A little of the time	7	15.21
3 = Some of the time	3	6.5
4 = A good part of the time	3	6.5
5 = Most or all of the time	0	0.0
TOTAL	46	99.91

Table 32 N = 46

Question 10. I feel afraid without good reason.

Responses	Frequencies	Percentages
1 = Rarely or none of the time	30	65.0
2 = A little of the time	5	10.8
3 = Some of the time	8	17.0
4 = A good part of the time	2	4.0
5 = Most or all of the time	1	2.0
TOTAL	46	98.8

Part III - Social Support Items

Table 33 N = 46

Question 1. My family tries to help me.

Responses	Frequencies	Percentages
1 = Very strongly disagree	3	6.5
2 = Strongly disagree	2	4.0
3 = Mildly disagree	3	6.5
4 = Neutral	3	6.5
5 = Mildly agree	10	21.7
6 = Strongly agree	6	13.0
7 = Very strongly agree	19	41.3
TOTAL	46	99.5

Table 34 N = 46

Question 2. I get the emotional help and support I need from my family.

Responses	Frequencies	Percentages
1 = Very strongly disagree	5	10.8
2 = Strongly disagree	3	6.5
3 = Mildly disagree	4	8.6
4 = Neutral	7	15.21
5 = Mildly agree	5	10.8
6 = Strongly agree	6	13.0
7 = Very strongly agree	16	34.7
TOTAL	46	99.61

Table 35 N = 46

Question 3. There is a special person (boyfriend) who is around when I am in need.

Responses	Frequencies	Percentages
1 = Very strongly disagree	4	8.6
2 = Strongly disagree	2	4.0
3 = Mildly disagree	1	2.0
4 = Neutral	6	13.0
5 = Mildly agree	9	19.5
6 = Strongly agree	6	13.0
7 = Very strongly agree	18	39.1
TOTAL	46	99.2

Table 36 N = 46

Question 4. There is a special person with whom I can share joys and sorrows.

Responses	Frequencies	Percentages
1 = Very strongly disagree	1	2.0
2 = Strongly disagree	1	2.0
3 = Mildly disagree	1	2.0
4 = Neutral	7	15.21
5 = Mildly agree	5	10.8
6 = Strongly agree	8	17.0
7 = Very strongly agree	23	50.0
TOTAL	46	99.01

Table 37 N = 46

Question 5. My friends really try to help me.

Responses	Frequencies	Percentages
1 = Very strongly disagree	2	4.0
2 = Strongly disagree	1	2.0
3 = Mildly disagree	5	10.8
4 = Neutral	9	19.5
5 = Mildly agree	9	19.5
6 = Strongly agree	8	17.0
7 = Very strongly agree	12	26.0
TOTAL	46	98.8

Table 38 N = 46

Question 6. I can count on my friends when things go wrong.

Responses	Frequencies	Percentages
1 = Very strongly disagree	4	8.6
2 = Strongly disagree	3	6.5
3 = Mildly disagree	1	8.6
4 = Neutral	12	26.0
5 = Mildly agree	6	13.0
6 = Strongly agree	10	21.7
7 = Very strongly agree	7	15.21
TOTAL	46	99.61

Table 39 N = 46

Question 7. I can talk about my problems with my family.

Responses	Frequencies	Percentages
1 = Very strongly disagree	5	10.8
2 = Strongly disagree	1	2.0
3 = Mildly disagree	8	17.0
4 = Neutral	8	17.0
5 = Mildly agree	6	13.0
6 = Strongly agree	7	15.21
7 = Very strongly agree	11	23.9
TOTAL	46	98.91

Table 40 N = 46

Question 8. My family is willing to help me make decisions.

Responses	Frequencies	Percentages
1 = Very strongly disagree	5	10.8
2 = Strongly disagree	4	8.6
3 = Mildly disagree	4	8.6
4 = Neutral	6	13.0
5 = Mildly agree	5	10.8
6 = Strongly agree	10	21.7
7 = Very strongly agree	12	26.0
TOTAL	46	99.5

Table 41 N = 46

Question 9. I have a special person who is a real source of comfort to me.

Responses	Frequencies	Percentages
1 = Very strongly disagree	2	4.0
2 = Strongly disagree	2	4.0
3 = Mildly disagree	1	2.0
4 = Neutral	2	4.0
5 = Mildly agree	4	8.6
6 = Strongly agree	5	10.8
7 = Very strongly agree	30	65.0
TOTAL	46	98.4

Table 42 N = 46

Question 10. There is a special person in my life who cares about my feelings.

Responses	Frequencies	Percentages
1 = Very strongly disagree	0	0.0
2 = Strongly disagree	4	8.6
3 = Mildly disagree	2	4.0
4 = Neutral	3	6.5
5 = Mildly agree	3	6.5
6 = Strongly agree	8	17.0
7 = Very strongly agree	26	56.5
TOTAL	46	99.1

BIBLIOGRAPHY

Armstrong, Bruce. "Adolescent Pregnancy." Encyclopedia of Adolescence, Vol. II. New York: Garland Publishing, (1991): 794-802.

Baldwin, W. and V. Cain. "The Children of Teenage Parents." Family Planning Perspectives 11 (4), (1980): 219-225.

Baldwin, W., Encyclopedia of Social Work, s.v. "Adolescent Pregnancy" by Rosina M. Becerra and Eve P. Fielder. Vol I, 18th ed. Silver Springs, Maryland: National Association of Social Workers

Barber, Robert L. Social Work Dictionary 2nd ed. National Association of Social Workers, Washington, D.C., 1991: 108.

Barrera, M., Jr. and S.L. Ainlay. "The Structure of Social Support: A Conceptual and Empirical Analysis." Journal of Community Psychology 11, 133-143.

Barrett, R. L. and B. E. Robinson. "A Descriptive Study of Teenage Expectant Fathers." Family Relations 31, (1982): 349-352.

Becerra, Rosina M. and Eve P. Filder. "Adolescent Pregnancy." Encyclopedia of Social Work Vol. I, 18th ed. Silver Springs, Maryland: National Association of Social Workers, inc. (1987): 40-50.

Bergman, Ann G. "Informal Support Systems for Pregnant Teenagers." Social Casework. The Journal is Contemporary Social Work (November 1989): 525-533.

Brown, M.A. "Social Support Stress and Health: A Comparison of Expectant Mothers and Fathers." Nursing Research 35, (1986): 72-76.

Card, J.E. and L. Wise. "Teenage Mothers and Teenage Fathers: The Impact of Early Childbearing on Parents Personal and Professional Lives." Family Planning Perspectives 10 (4), (1978): 199-218.

Cervera, Neil. "Unwed Teenage Pregnancy: Family Relationship with the Father of the Baby." Families in Society: The Journal of Contemporary Human Services. Family Services American (1991): 29-37.

Coates, Deborah L. and Brigit Van Widenfelt. "Pregnancy in Adolescence." Encyclopedia of Adolescence Vol. II (New York: Garland Publishing, Inc., 1991).

Colletta, N.D. "Social Support and the Rish of Maternal Rejection." Journal of Psychology 109, (1981): 191-197.

Coopersmith, S. "The Antecedent of Self-Esteem." San Francisco: Freidman (1967).

De Anda, D. and R.M. Becerra. "Support Networks for Adolescent Mothers." Social Casework 65, (1984): 172-181.

Epstein, S. "Anxiety, Arousal, and the Self-Concept." Issues in Mental Health in Nursing Vol 10 (1985): 265-305

Frodia, A. "Determinants of Attachment and Mastery Movation in Infants Born to Adolescent Mothers." Infant Mental Health Journal 5, 15-23.

Freedman, Alfred, M.D. Modern Synopsis of Comprehensive Textbook of Psychiatry II. The Williams & Williams Company, 428 E. Preston Street, Copyright 1976, 137.

Furstenberg, Frank F. "Pregnancy and Childbearing: Effects on Teen Mothers." Encyclopedia of Adolescence Vol. II, New York: Garland Publishing, Inc., 1991, 803-807.

Gibbs, Jewell Taylor, Larke Nahme Huang and Associates. Children of Color. San Francisco: Jossey-Bass Publishers, 1989.

Gottlieb, B.H. "The Development and Application of a Classification Scheme of Informal Helping Behavior." Canadian Journal of Behavioral Science 10, 105-115.

Goutes, Deborah L. and Brigit Van Widenfelt. "Pregnancy in Adolescence." Encyclopedia of Adolescence Vol. II, New York: Garland Publishing, Inc., 1991.

Griddin-Koniak, Deborah, Susan Lominska and Mary Lynn Brecht. "Social Support During Adolescent Pregnancy, A Comparison of Three Ethnic Groups." Journal of Adolescence Vol 16, No. 1, 43-56.

Hudson, Walter W. The WALMYR Assessment Scales Scoring Manual. Tempe, Arizona: WALMYR Publishing Company, 1992.

Jones, E.F., J.D. Forrest, N. Golman, S. Henshaw, R. Lincoln, J.I. Rosoff, C.F. Westoff, and D. Wulf. "Teenage Pregnancy in Westernized Countries." New Haven: Yale University Press, 1986.

Lander, Joyce. "Teenage Pregnancy: The Implication for Black Americans." Washington, D.C.: New Direction, 1985, 65-84.

Liese, Lawrence H., Lonnie R. Snowden, and Lucy K. Ford. "Partner Status Social Support and Psychological Adjustment During Pregnancy." Family Relations No. 36, (July 1989): 311-316.

McKenna, Matthew T., M.D., M.P.H. and Paul J. Wiesner, M.D. "Evaluation of the Consensus Health Status Indicator for Assessing Adolescent Pregnancies and Birth." Public Health Reports in Brief, Vol. 109, No. 4, July - August (1994).

O'Reilly, P. "Methodological Issues in Social Support and Social Network." Research Social Science Medicine 26 (8), 1988: 863-873.

Pattison, E.M. "A Theoretical Empirical Base for Social Support." In E.F. Foulks, R.M. Wintrob, J. Westermeyer, an A.R. Favazza (eds.) Current Perspectives in Cultural Psychiatrict. New York: Spectrum, (1977): 217-253.

Records, Kathryn A. "Life Events of Pregnant and Non Pregnant Adolescents." Adolescence Vol. 28, No. 110 (Summer 1993).

Robinson, Rachel B. and Deborah E. Frank. "The Relations Between Self Esteem, Sexual Activity, and Pregnancy." Adolescence Vol 29, No. 113 (Spring 1994): 28-35.

Rubestine, Elaine, Susan Panzarine and Patrician Lanning. "Peer Counseling with Adolescent Mothers: A Pilot Program." Families in Society: The Journal of Contemporary Human Services (1990): 136-141.

Streeter, Calvin L. and Cynthia Franklin. "Defining and Measuring Social Support: Guidelines for Social Work Practice, Vol. 2, No. 1 (January 1992): 81-89.

Thompson, Maxine Seaborn and Wilma Peebles-Wilkins. "The Impact of Formal, Informal and Societal Support Networks on the Psychological Well Being of Black Adolescent Mothers." Social Work Vol. 37, No. 4 (July 1992): 322-328.

Trimpley, M.L. "Self-Esteem and Anxiety in an Abused Women Support Group." Issues in Mental Health in Nursing Vol. 10, (1988): 297-308.

Trusell, James. "Teenage Pregnancy in the United States." Family Planning Perspectives Vol. 20 (1988): 262-272.

Turner, R. Jay, Carl F. Grindstaff, and Norman Phillips. "Social Support and Outcome in Teenage Pregnancy." Journal of Health and Social Behavior Vol. 3 (March 1990): 43-57.

Ventura, S.J. and R.L. Heuser. "Trends in Teenage Childbearing, United States." 1970-81 Vital and Health Statistic Series 21, No. 41, DHHS Pub. No. (PHS) 84-1919; Rockville, Maryland: National Center for Health Statistics, (Sept. 1984): 3.

Wells, L.E. and G. Marwell. "Self Esteem, Its Conceptualization and Measurement." Issues in Mental Health in Nursing Vol. 10, (1988): 299.

Wethington, Elaine and Ronald C. Kessler. "Perceived Social Support and Adjustment to Stressful Life Events." Journal of Health and Social Behavior 27 (1986): 78-90.

Zimet, G.D., N.W. Dahlem, S.G. Zimet and G.K. Farley. "The Multidimensional Scale of Perceived Social Support." Journal of Personality Assessment 52 (1988): 30-41.